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6	Sacramento, CA 94244-2550 Telephone: (916) 322-5524		
7	Facsimile: (916) 327-8643 Attorneys for Complainant		
8		FORE THE	
9	BOARD OF VOCATIONAL NURSING AND PSYCHIATRIC TECHNICIANS DEPARTMENT OF CONSUMER AFFAIRS		
10	STATE O	F CALIFORNIA	
11	In the Matter of the Accusation Against:	Case No. VN-2007-1082	
12	ARLYN M. DE LA CRUZ		
13	1633 S. Stockton Street Stockton, CA 95206	ACCUSATION	
14	Vocational Nurse License No. VN 188159		
15	Responder	nt.	
16	Complainant alleges:		
17	<u>P.</u>	ARTIES	
18	1. Teresa Bello-Jones, J.D., M.S.N.,	R.N. ("Complainant") brings this Accusation solely	
19	in her official capacity as the Executive Officer of the Board of Vocational Nursing and		
20	Psychiatric Technicians ("Board"), Department	nt of Consumer Affairs.	
21	2. On or about May 3, 1999, the Boa	ard issued Vocational Nurse License Number	
22	VN 188159 to Arlyn M. De La Cruz ("Respor	ndent"). Respondent's vocational nurse license was	
23	in full force and effect at all times relevant to	the charges brought herein and will expire on	
24	December 31, 2012, unless renewed.		
25	STATUTORY AND REGULATORY PROVISIONS		
26	3. Business and Professions Code ("Code") section 2875 provides, in pertinent part, tha		
27	the Board may discipline the holder of a vocational nurse license for any reason provided in		
28	Article 3 (commencing with Code section 2875) of the Vocational Nursing Practice Act.		

COST RECOVERY

8. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

- 9. At all times relevant herein, Respondent was employed as a licensed vocational nurse at Whispering Hope Care Center located in Stockton, California.
- 10. On or about October 28, 2007, at approximately 1910 hours, Respondent inserted a Foley catheter for a male resident (hereinafter "patient")¹ as ordered by the patient's physician. At approximately 1910 hours, Respondent checked the patient and observed that there was no urine output. Respondent decided to observe the patient's urine output for an additional 2 to 3 hours by increasing the patient's fluid intake to 600 cc during her shift while initiating an intake and output protocol.
- 11. Respondent is subject to disciplinary action pursuant to Code section 2878, subdivision (a)(1), on the grounds of unprofessional conduct, in that Respondent was guilty of gross negligence in her care of the patient within the meaning of Regulation 2519, as follows:
- a. Respondent failed to assess the patient for hydration of the oral mucosa or skin turgor.
- b. Respondent failed to document in the Licensed Nurses Progress Notes the insertion of the catheter, the lack of urine flow, the initiation of Intake and Output protocol with a form to reflect the increased intake, and the output assessments.
- c. Respondent failed to notify the patient's physician and/or the registered nurse on duty of the patient's lack of urine output.

¹ The patient's diagnoses included septic shock, altered consciousness, hypertension, congestive heart failure, chronic obstructive pulmonary disease, and diabetes mellitus, insulin dependent.

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	DATED: May 17, 2011.	fluor Jesto- au
4	DATED	TERESA BELLO-JONES, J.D., M.S.N., R.N. Executive Officer
5		Board of Vocational Nursing and Psychiatric Technician
6		Department of Consumer Affairs State of California Complainant
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